Sample OBAT Treatment Agreement

OBAT TREATMENT AGREEMENT

I freely and voluntarily agree to accept this treatment agreement, as follows.

I agree to do my best to keep my scheduled appointments with my provider and nurse and that it is my responsibility to call the clinic if I will be late/early or need to reschedule my appointment.

I will report any substance use and discuss high-risk behaviors with my treatment team. Being clear about these will help decrease my risk of overdose or infection and will protect my safety.

If I continue to struggle with ongoing substance use, my treatment plan may be changed, and this could require transfer to more intensive treatment.

I will attend my appointments prior to running out of prescriptions and keep my medication in a safe and secure place. I understand that my medication might not be refilled early, even if it is lost or stolen.

I will inform my provider if the medication I am receiving no longer works for me so that we can make a new treatment plan.

I agree not to sell, share, or give away any of my medication.

I will not engage in behavior that jeopardizes the safety of anyone in the clinic. Doing so may be considered reason for discharge from the program.

I will not falsify or tamper with drug tests. I understand that if I test positive for substances not prescribed to me, or if I test negative for substances that are prescribed to me, my treatment plan will be adjusted (for example, I may be asked to return to clinic more frequently).

I agree to random call-back visits that include toxicology screens and medication counts, which require me to respond within 24 hours by telephone.

I agree that if I obtain medication from any other prescribers, pharmacies, or sources that I will inform my OBAT team.

I understand that mixing buprenorphine with other substances, especially those which can cause sedation such as benzodiazepines or alcohol, can be dangerous. I understand that deaths have been reported among persons mixing buprenorphine with sedating substances.

If I am able to become pregnant and am of childbearing age, I will alert my health provider if there is a chance that I am pregnant so they can assist me in the proper steps to keep me and my unborn baby safe. This does not mean I will be discharged from treatment.

If at any time I am discharged from this program I may be reconsidered at a future time.

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Witness Printed Name	Signature	Date

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